V. S. No. 2
0M—5-42
ev. 5-17-39
P I X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 16980

FILED JUN 7 1943
Registration District No. [illegible]49

Primary Registration District No. 1002

Registrar's No. 2203

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wheatley Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether years, months or days)
In this community 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City (If outside city or town limits, write "RURAL") 9
(d) Street No. 1539 Aline Apt. 12 (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Wilma Mitchell Hubly
3. (b) If veteran, name war no
3. (c) Social Security No. Unable to find #

4. Sex Female 2
5. Color or race Negro
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Walter W. Hubly
6. (c) Age of husband or wife if alive 24 years
7. Birth date of deceased 4 (Month) 4 (Day) 1912 (Year)

8. AGE: Years 31 | Months 1 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Oklahoma City (City, town, or county) Oklahoma (State or foreign country)
10. Usual occupation maid
11. Industry or business Laramee apt.
FATHER
12. Name Unknown 9
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Leola Williams
15. Birthplace Oklahoma (City, town, or county) (State or foreign country)
16. (a) Informant Walter W. Hubly
(b) Address 1539 Aline
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-12-43 (Month) (Day) (Year)
(c) Place: burial or cremation Oklahoma City, Okla.
18. (a) Signature of funeral director Emb. Casket Co. by J. W. Joyner K.C.
(b) Address 440 State Line M. M. Brown
19. (a) 5-12-43 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 10 year 1943 hour 2 minute 55-9 M.
21. I hereby certify that I attended the deceased from 5/8/43, 19__, to 5/10/43, 19__; that I last saw her alive on 5/10/43, 19__; and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Ectopic Gestation
Due to Ruptured R. Fallopian Tube
Due to 14 a

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy Rupture right Tube Hemorrhage right cavity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Dr. V. Miller (M. D. or other)
Address 203 Pasco Bldg. Date signed 5/11/43

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Eugene Englisch

Licensed Embalmer No. 4103

P. O. Address 440 State ave. K. C. 1

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.